EXHIBIT A

HONDA

A Guide to Your Benefits

Honda is pleased to provide you with this Summary Plan Description (SPD): *"A Guide to Your Benefits."* Your benefit plans are an important part of your total rewards package that Honda provides for you and your family

The SPD provides information about the plan provisions governing your benefits — including eligibility, coverage levels and plan guidelines. Consider this SPD, which is available both in print and online at mypal.hondaalabama.com, to be your primary reference guide for your benefits — the first place to turn when you have a question about your rights as a plan participant.

This SPD is available in print and online at mypal.hondaalabama.com.

Contents

About This Guide

This SPD is designed to help you understand how your benefits work. Please refer to it when you have questions about your benefit plans. If you have a family, be sure to share the guide with them as well.

This guide is divided into sections describing each benefit plan, as shown in the table of contents. For details about a specific plan, refer to that section. There, you will find another table of contents to help you find what you are looking for in the benefit plan section.

If You Have Questions

If you have questions about the information in this guide, contact the Honda Benefits Service Center at www.myhondabenefits.com or by calling 1-866-778-5885 from 10:00 a.m. - 9:00 p.m. ET, Monday - Friday. This guide is also available online.

This guide is the Summary Plan Description (SPD) for the Honda Manufacturing Health & Welfare Benefits Plan and the retirement plans offered by Honda Manufacturing of Alabama, LLC (referred to as "Honda" in this guide).

Associates of other affiliated companies also participate in these plans; however, benefits may vary by group or location. Benefits for the associates of other affiliated employers or companies are described in separate SPDs.

A complete list of participating employers for the plans described in this SPD is included in the *Administrative Information* section and also is available from the Honda Benefits Service Center at www.myhondabenefits.com or by calling 1-866-778-5885 from 10:00 a.m. - 9:00 p.m. ET, Monday - Friday.

Note: Insured (health and welfare) benefits are also subject to the terms of the insurance certificates, policies or contracts of coverage. The Summary Plan Description, along with the insurance certificates, policies or contracts of coverage for the health and welfare plans listed in the *Administrative Information* section, are considered the official plan documents for those plans. This guide is not considered a plan document for the retirement plan(s) listed in the *Administrative Information* section. It is a summary only of information that is included in legal plan documents for those plans, and in all such cases, the legal plan documents will determine how those plans are administered.

About the Benefit Plans

This SPD is for active Honda associates employed by Honda Manufacturing of Alabama, LLC. Your participation in these benefit plans does not guarantee continued employment with Honda.

The persons set forth below are not eligible for, and may not participate in, the benefit plans described in this SPD:

- Any self-employed person who provides services to Honda through an agreement between Honda and that person
- Any person employed by or who obtains employment through a company that provides temporary workers to Honda
- A student or temporary associate
- An associate of an international affiliate on temporary assignment at Honda

The plan sponsor for each plan has the sole right to terminate, suspend, withdraw, amend or modify the benefit plans described in this guide in whole or in part at any time. These actions may affect plans covering any associates.

Important to Remember

Honda's practices, policies and benefits for U.S. associates are outlined here for your information as required by law. However, this does not constitute an implied or express contract or guarantee of employment.

Please read this material carefully and keep it for future reference. If you have questions about this information or your Honda benefit plans, contact the Honda Benefits Service Center at www.myhondabenefits.com or by calling 1-866-778-5885 from 10:00 a.m. - 9:00 p.m. ET, Monday - Friday.

Your Benefits: A Complete Package

Honda provides a complete and competitive benefits package to eligible associates. Many of these benefits are paid for entirely by Honda.

Honda benefits provide a broad range of assistance, as shown in the following chart. For details about a specific plan, refer to that section within this guide.

Your Situation	Honda Provides	See This Section
If You Need Healthcare...	• Medical Plan	*Medical Plan*
	• Prescription Drug Plan	*Prescription Drug Plan*
	• Dental Plan	*Dental Plan*
	• Vision Plan	*Medical Plan*
If You Have Dependents...	• Healthcare Coverage	See the "If You Need Healthcare..." row above for more information about the sections to review
	• Supplemental Term Insurance	*Supplemental Insurance Plans*

Your Situation	Honda Provides	See This Section
If You Become Disabled...	• Short-Term Disability	*Disability Plans*
	• Long-Term Disability	*Disability Plans*
If You Are Injured at Work...	• Workers' Compensation	*Other Services and Programs*
For Protection Against Loss of Life or Limb...	• Basic Life and Accident Insurance	*Life and Accident Insurance*
	• Business Travel Insurance	*Life and Accident Insurance*
	• Supplemental Term Insurance	*Supplemental Insurance Plans*
For Time Away from Work...	• Paid Time Off	*Other Services and Programs*
	• Holidays	*Other Services and Programs*
	• Family and Medical Leave	*Administrative Information*
To Further Your Education...	• Honda Educational Reimbursement	*Other Services and Programs*
For Your Health and Safety...	• Safety Shoes/Glasses	*Other Services and Programs*
	• Wellness Center Membership	*Other Services and Programs*
For Home and Personal Issues...	• Associate Assistance Program	*Other Services and Programs*
For Financial Conveniences...	• Direct Deposit	*Other Services and Programs*
	• Credit Union	*Other Services and Programs*
	• Product Purchase	*Other Services and Programs*
For Ownership in Honda...	• Stock Purchase Plan	*Other Services and Programs*
When You Retire...	• Pension Plan	*Pension Plan*
	• 401(k) Savings Plan	*401(k) Savings Plan*
	• Retirement Medical Program	*Other Retirement Benefits*
	• Retiree Life Insurance	*Other Retirement Benefits*
	• Other Benefits	*Other Retirement Benefits*

Concurrent Review and Discharge Planning

The following items apply if the plan requires certification of any confinement, services, supplies, procedures or treatments:

- **Concurrent Review.** The concurrent review process assesses the necessity for continued stay, level of care and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review
- **Discharge Planning.** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay

Provider Networks

If plan benefits differ depending on whether care is given by, or accessed through, a network provider, you may obtain, without charge, a listing of network providers from Blue Cross and Blue Shield of Alabama by calling the toll-free Member Services number on your ID Card. A current list of providers in the Blue Cross and Blue Shield of Alabama network is also available through Find a Doctor, at www.bcbs.com.

Further Information

If you or your beneficiary still believes that a claim has been improperly denied, you or your beneficiary may have additional rights, which are explained in the "Statement of ERISA Rights" on page 224.

Disability

Short-Term Disability

If all or part of your claim for disability benefits is denied, you will receive a written notice of the denial generally within 28 days of filing the claim (or within 28 days of your First Day Absent if claim is future dated). If your claim does not include necessary information, the claim administrator may either deny your claim or contact you to obtain the missing information. You have the right to request a review and reconsideration of your claim from the claim administrator (two levels of appeal are available) but such request must be made within 180 days after notice of the initial denial of the claim. In order to help you in refiling the claim, the denial notice will give you:

- The specific reason for the denial
- The specific references to the plan provisions on which the denial is based
- A description of the plan's review procedures and time limits
- Your right to receive upon request a copy of any internal rules, guidelines, protocols or other similar criteria used as a basis for the denial

You may request copies of all documents, records and other information relevant to your denied claim. You may also request access to:

- Any policy, statement or guidance concerning the denied treatment option or benefit for your diagnosis, regardless of whether it was relied on in the denial
- The identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, regardless of whether the advice was relied on in the denial

All requests submitted to the claim administrator must be made in writing with your signature.

A decision on appeal is usually made within 45 days of when it is received. In the event an extension is necessary, the claim administrator will notify you before the original deadline explaining the circumstances requiring delay and the date when the claim administrator expects to make a decision. You may request an extension to submit additional medical information while your claim is in the appeal process. The claim administrator's decision on appeal is final. The claim administrator's notification to you will include the same notification (if applicable) as included in the initial adverse benefit determination notification.

Long-Term Disability

If all or part of your claim for disability benefits is denied, you will receive a written notice of the denial generally within 45 days of filing the claim. If your claim does not include necessary information, the claim administrator may either deny your claim or contact you to obtain the missing information. If you are contacted, you will be given a period of at least 45 days to provide the missing information. If due to matters beyond its control the claim administrator needs more time to decide a claim, it may take up to two 30-day extensions. If an extension is taken, you will be notified of the circumstance and the date by which the claim administrator expects to decide the claim. You have the right to request a review and reconsideration of your claim from the claim administrator but such request must be made within 180 days after notice of the initial denial of the claim. In order to help you in refiling the claim, the denial notice will give you:

- The specific reason for the denial
- The specific references to the plan provisions on which the denial is based
- A description of any additional material or information needed to complete the claim and why it is needed
- A description of the plan's review procedures and time limits
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following a denial of your claim on appeal
- Your right to receive upon request a copy of any internal rules, guidelines, protocols or other similar criteria used as a basis for the denial

You may request copies of all documents, records and other information relevant to your denied claim. You may also request access to:

- Any internal rules, guidelines, protocols or similar criteria that were relied on in the denial
- The identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, regardless of whether the advice was relied on in the denial

All requests submitted to the claim administrator must be made in writing.

A decision on appeal is usually made within 45 days of when it is received or 90 days in special cases. In the event an extension is necessary, the claim administrator will notify you before the original deadline explaining the circumstances requiring delay and the date when the claim administrator expects to make a decision. The claim administrator's decision on appeal is final. The claim administrator's information to you will include the same information (if applicable) as included in the initial adverse benefit determination notification.

If you or your beneficiary still believes that a claim for Long-Term Disability benefits has been improperly denied, you or your beneficiary may have additional rights, which are explained in the "Statement of ERISA Rights" on page 224.

Other Welfare and Retirement Benefits

If you file a claim for your benefit under the plan and your claim is denied in whole or in part, you will be notified in writing. The notification will include:

- The reason for the denial
- The specific references to the plan provisions on which the denial is based
- A description of any more material needed to complete your claim and why it is needed
- An explanation of the plan's claims review procedures, including an explanation of your right to bring a civil action under section 502(a) of ERISA following an adverse determination on appeal

Generally, you should receive the notice 90 days after the claim is filed or in special cases, within 180 days after the claim administrator receives your request. In the event an extension is necessary, the claim administrator will notify you before the original deadline explaining the circumstances requiring the delay and the date when the claim administrator expects to make a decision.

If your claim is denied and if you believe that you were improperly denied benefits under the plan, you have the right to have your claim denial reviewed. To do so, you must submit a written request to the claim administrator of that plan within 60 days of receiving the notice of denial. For Pension Plan and 401(k) Savings Plan appeals, the claim administrator is the plan administrator. If possible, you should include any documents or records that support your appeal. You have the right to review all pertinent plan documents.

You will receive a written decision on your appeal within 60 days of the date the claim administrator receives your request or in special cases, within 120 days after the claim administrator receives your request. If special circumstances require a delay, you will be notified of the extension during the 60 days following the receipt of your request or request for review. The claim administrator's notification to you will include the same notification (if applicable) as included in the initial adverse benefit determination notification.

If a claim for benefits or request for review is denied, you have certain rights under the law. For more information, see the "Statement of ERISA Rights" on page 224.

Statute of Limitations

Any legal proceeding to recover denied benefits under any plan may not be instituted until all administrative remedies are exhausted, and in no case may legal action be brought beyond one year after the date notification of an adverse determination on appeal is issued.